Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Danielle Rising_____ Day/Date: 1/31/24

Number of Clinical Hours Today: __10__ Care Setting: __x_ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: _10____ Preceptor: ___Janie Renaud_____

Journal Focus: _____Wound _____ Ostomy ___x___Continence _____Combination Specify: _____

Directions: WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, select one patient each clinical day. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care. Provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor. Submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day. See samples in course to assist you with this assignment.

Today's WOC specific assessment	**Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.** This is a 60 year old male with a past medical history of acute coronary syndrome, inferior wall STEMI and underwent PTCA of RCA without PCI complicated by RCA perforation. He was previously hospitalized for 3 months in 11/2023 (at the Medical Center of Cozumel) due to dengue fever, zika virus, and NBE. He traveled to Florida for medical care on 12/6/23. He was also found to have positive urine cultures on 12/13/23 for Enterobacter. He presents to the ED this admission for generalized weakness. Patient states he has not been able to adequately care for himself. The patient reports being unable to quickly reach the toilet or commode in a timely manner, leaving himself soiled for an extended amount of time. Patient reports skin irritation and tenderness to the buttocks and inner groin for approximately 3 weeks.

Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, *interactions, and specific products that were used/recommended for use.*

The WOC nurse consultant/specialist note should begin with why you are seeing the pt; Initial visit for…, follow- up visit for…, evaluation and management of…, etc Then, describe the visit. Write in a manner others will be able to understand and be able to interpret your plan of care.

This is the follow up visit for assessment of this patients' buttocks wounds. After introducing self and informing the patient of the visit, the patient was cooperative and agreeable to assessment. The patient was up in the chair at time of assessment and states that a Hoyer lift was used to place him in the chair. Per the patient, he was only in the chair for approximately 45 minutes. He wanted to remain in the chair and states he cannot stand or turn independently. This patient was agreeable to recline the chair and turn while remaining in the chair. The patient was turned to the left side with maximum assistance. It was noted that his bilateral lower extremities were only slightly able to lift the heel and leg off the chair's surface. Bilateral heels were assessed while the patient was turned to the side, reveals pink, intact, blanchable skin. Peri-care was provided with pre-moistened soft disposable wipes for an episode of stool incontinence. Urinary incontinence also present; external male suction catheter misplaced, incorrectly working and removed. Zinc barrier paste was previously applied to the sacrum and was gently removed using adhesive remover wipes to allow

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for complete assessment. Patients report no pain to this area. Once cleaned, patients' sacrum presented with scattered, partial thickness wounds with blanchable moist, pink wound bases in an irregular shape. There is peeling skin noted to the distal portion of the sacrum. The surrounding skin is hyperpigmented, likely due to chronic moisture exposure with epidermal disruption. There appears to be fungal indicators to the surrounding skin as well, due to prolonged moisture exposure. The entire area measures 6.5cm x 4.0cm x 0.1cm. There is a central area that appears darker and is non-blanchable, however, the borders of this area are irregular and not over a bony prominence. There are no indicators of this area resulting from prolonged pressure at the muscle-bone interface, the area is not indicative of ischemia, nor is this area boggy. This area has likely developed due to moisture erosion occurring at different levels. The etiology of this wound is unlikely to be related to pressure. WOC will reassess in 3 days to assess wound progression which will determine etiology. Triad barrier paste was applied to the patient's entire sacrum and buttocks. The patient was then rolled back in the supine position. The patient states that he is able to identify times when voiding is necessary, however he is unable to reach the toilet. This type of incontinence can be identified as functional incontinence. The patient was educated to call the nurse using the "red button" when the patient is about to or experiences bowel or bladder incontinence. Timed voiding was discussed with the patient and the patient is agreeable to plan on an every 2 hour schedule. Kegel exercises were discussed with the patient as well; the patient agrees to initiate Kegel exercises to strengthen the pelvic floor muscles. The patient was turned and repositioned to the left side using pillow support. TruVue pressure reduction boots applied to the bilateral heels. The patient is on a pressure redistribution specialty bed. The bedside nurse was informed of the findings and educated to return the patient back to the bed in 1 hour. Miconazole powder ordered for fungal indicators.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc***	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
1. Severe moisture associated skin damage related to fecal and urinary functional incontinence.	1. nursing to provide peri-care for this patient when the patient calls for incontinence. This is to be done within 10 minutes of the patient calling. Patient was educated regarding timed voiding. Timed voiding should be performed every 2 hours. Nursing is to offer the use of a urinal every 2 hours to promote timed voiding. If nursing notices that the patient is calling more often than 2 hours, decrease the frequency of timed voiding to every 1 hour. Avoid the use of the external male suction catheter urinary collection device.	1. prompt cleansing will decrease the length of time that moisture is exposed to the skin. Offering the use of a urinal every 2 hours will allow the patient to adjust to timed voiding. If the patient is voiding more often, increasing the intervals of offering the urinal will allow the patient to meet his goals. Avoiding the use of this external urinary collection device will promote patient independence with

		voiding.
	Encourage the patient to use a bedpan to collect stool. Nursing offers this use during the planned every 2-hour schedule.	Encouraging the patient to use a bedpan will promote patient with independence in voiding.
	Patient was educated on the use of Kegels to increase the strength of the pelvic floor muscles. Continue to encourage the patient to perform 10 rapid contractions followed by 10 slow contractions 4 times daily. Remind the patient to perform these exercises every 4 hours.	Initiating Kegel exercises will strengthen the pelvic floor muscles. Starting out with lower reps will prevent muscle fatigue. Preventing muscular fatigue will allow the muscles to strengthen.
	Encourage the patient to drink 6-8 cups of water daily unless otherwise contraindicated per physician.	Dehydration may worsen the patient's incontinence episodes. Encouraging fluid intake will also prevent constipation which could also worsen urinary incontinence episodes.
	Cleanse the patient after incontinence episodes using warm water and mild soap. Again, this is to be performed within 10 minutes of the patient informing the nurse. Adhesive remover can be used to remove the soiled portions of the Triad paste. Reapply Triad barrier paste after cleansing.	Reapplying after cleansing is crucial since the soiled paste is removed during cleansing.
	Apply Triad barrier paste to the bilateral buttocks and sacrum at least twice daily. Reapply triad barrier paste after cleansing during times of incontinence. Apply miconazole powder beneath the barrier paste.	Ensuring the application of triad BID is crucial to allow the skin to heal and to prevent from additional moisture damage. Miconazole powder will aid to treat the fungal indicators noted to the peri-wound. Reapplying after cleansing is crucial since the soiled paste is removed during cleansing.
	Assess the patient's buttocks BID at the start of each shift. Remove Triad barrier paste using adhesive remover. Notify WOC nursing of any alterations.	Assessing the patients buttocks BID will aid in identification of additional breakdown, worsening areas or new areas of concern. Removing the barrier paste using adhesive remover will prevent stripping the skin during cleansing.
2. limited mobility related to the new onset of weakness.	2. use a P500 low air loss mattress specialty bed.	This bed aids in pressure redistribution and increases the airflow beneath the patient.

	Limit the number of layers beneath the patient. Do this by only using one chuck.	Limiting the number of layers will decrease the amount of pressure exerted to the area and allow for airflow to reach the area.
	Turn and reposition the patient every 2 hours while in bed.	Repositioning the patient every 2 hours will prevent the risk of developing pressure injuries.
	Use a chair cushion when the patient is sitting up in the chair. Reposition the patient every 1 hour while up in chair.	A chair cushion will prevent pressure exerted to one area while up in chair. Repositioning every 1 hour while up in chair will reduce the risk of developing pressure injuries. Repositioning more frequently is due to the angle created while sitting up. This angle exerts pressure to the patients coccyx area.
	Ensure the patients heels are lifted off the beds surface or chairs surface when reclined. Do this by utilizing TruVue offloading boots.	Offloading the heels off of the surface will prevent pressure exerted to one area.
	Assess the patients heels BID at the start of shift change. Notify WOC nursing of any alterations.	Assess the heels BID will allow prompt intervention needed by the WOC nurse.
	Consult placed to physical therapist to initiate muscle strengthening.	Muscle strengthening and initiation of standing and walking will strengthen the patients obturator adductor and pectineus muscles. These muscles can aid in pelvic floor continence.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Adhesive remover: can aid to easily remove barrier paste for assessment. Barrier paste can be removed without rubbing or stripping the skin, avoiding friction. This may not be readily available. Alternative: warm water and mild soap. Mineral oil or baby oil. This can aid for ease in removal of barrier paste. Warm soap and water on a soft towelette can also remove the paste, however, may require more work. No rinse perineal spray aids in barrier paste removal as well. TruVue offloading boots: lifts the heels off the bed surface to prevent prolonged pressure to the area. This will decrease the patients' risk of developing a pressure injury on the heel. Patients may find these pressure reduction boots to be hot or bulky. Alternative: offloading the heels using pillow support. Be sure to use a fluffier pillow to maintain pillow support. Hilrom P500 low air loss mattress: A pressure redistribution specialty mattress that pumps airflow throughout the mattress. This airflow will aid in allowing the patients buttocks to heal. This specialty

	bed is added to the patients insurance bill. Alternative: isogel bed pump. This bed pump is readily available in the hospital and can be applied to the standard bed. This air pump mimics the same specialty features as the P500. Triad: a hydrophilic barrier paste that protects the skin from moisture and can adhere to wet skin. Disadvantage: this specific barrier paste may not be available at every facility. Alternative: a barrier paste that contains zinc oxide. External male suction catheter: this external urinary collection device is a noninvasive way to collect urine to keep the patient clean and dry. Disadvantage: this product may not work on every patients anatomy, causing urine leakage and a soiled buttocks. This can cause MASD. Alternative: timed voiding and use of a hospital urinal. This encourages the patient in excretion independence and promotes the patient's continence. This also is more reliable in ensuring the patient is clean and dry.

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	My goal for today was an incontinence patient. I was able to see this and expand my knowledge related to differing levels of moisture erosion. I was able to learn distinguishing factors for severe MASD and a potential DTI. I was able to meet my goal for today.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to care for another continence patient to put what I learned today into action.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	The patient was assessed in the reclining chair. I wish I would have Hoyered this patient back to the bed for assessment to allow for a more comfortable roll.
Reflection: Describe other patient encounters, types of patients seen.	Today, I was able to check on my ECF patient from yesterday and I am pleased to inform you that our dressing/pouch is still in place, with a great seal and is collecting output!

Reviewed by: _____ Date: _____

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